Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROBERT BEDFORD DC
3100 TIMMONS LANE #250
HOUSTON TX 77027

Respondent Name
INDEMNITY INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-13-0686-01

MFDR Date Received
NOVEMBER 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note from the attached testing results & supporting documentation that all components for this claim were performed and billed appropriately using the TDI-DWC Fee Guidelines and should not be reduced. The claim was billed per Medical Fee Guideline conversion factors as established in 28 Texas Administrative Code 134.203."

Amount in Dispute: $24.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19, 2012	CPT Code 97750 – 16 Units	$24.65	$24.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional services
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment.

Issues

1. Were the disputed services paid in accordance with the Medical Fee Guideline?

2. Is the requestor entitled to reimbursement?

Findings

1. Review of the documentation submitted by the requestor finds that the healthcare provider was referred by Designated Doctor Teresa Oswald to perform and FCE. The requestor performed the FCE and billed the insurance carriers Third Party Administrator, Gallagher Bassett, Plano. The respondent's Third Party Administrator issued reimbursement in the amount of $795.04 and used payment exception code W1 – "Workers' Compensation State Fee Schedule Adjustment." In accordance with 28 Texas Administrative Code §134.203(b)(1) for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers… and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Per 28 Texas Administrative Code §134.203(c)(1) which states in part, "To determine the MAR for professional service, system participants shall apply Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation… when performed in an office setting, the established conversion fact to be applied is $54.86.
2. Review of the submitted documentation finds that Gallagher Bassett has not paid the services in accordance with 28 Texas Administrative Code §134.203(c)(1). The correct payment is calculated as follows:
   - (54.86 ÷ 34.0376) x $31.82 x 16 units = $820.57

   The requestor has supported the services were rendered as billed and is seeking additional reimbursement in the amount of $24.65.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $24.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $24.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 27, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.